An Analysis and Evaluation of Certificate of Need Regulation in Maryland

Inpatient Psychiatric Services

Response to Written Comments on the Staff Recommendation

MARYLAND HEALTH CARE COMMISSION

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I. Introduction

The Maryland Health Care Commission's working paper, titled *An Analysis and Evaluation of Certificate of Need Regulation in Maryland: Inpatient Psychiatric Services,* was developed as one in a series of working papers examining major policy issues of the Certificate of Need (CON) process, as required by House Bill 995 (1999). The paper presented the following six alternative regulatory strategies to the current Certificate of Need Requirement to establish or expand inpatient psychiatric services in Maryland:

Option 1: Maintain Existing Certificate of Need Program Regulation

Option 2: Expand Certificate of Need Program Regulation

Option 3: Deregulate Creation of Additional Levels of Inpatient Psychiatric Services from Certificate of Need Review

Option 4: Deregulate Inpatient Psychiatric Services from Certificate of Need Review; Create Data Reporting Model

Option 5: Deregulate Mental Hygiene Administration Hospitals from Certificate of Need Review

Option 6: Deregulate Inpatient Psychiatric Services from Certificate of Need Review

The Commission released the Working Paper on June 21, 2001, and invited interested organizations and individuals to submit written comments by July 23, 2001. The Commission subsequently received comments from 10 facilities or organizations. All of the comments supported maintaining current CON regulation for inpatient psychiatric beds and facilities, but a strong consensus also emerged that CON regulation was far from the most serious challenge facing the provision of these services, across all three inpatient settings.

On September 13, 2001, Staff presented its recommendation that the Commission adopt Option 1, Maintain Existing Certificate of Need Program Regulation. Staff also proposed that the Commission consider recommending Option 2, which as described would have added a provision to current statute governing hospital service closures requiring a higher level of review if a proposal to close a psychiatry unit compromised access to the service, and Option 3, which proposed removing the State Health Plan requirement that an inpatient adult

psychiatry unit obtain separate CON approval to provide the service to children or adolescents. The Commission invited interested organizations and individuals to submit written comments on Staff's summary and analysis of public comments, and its proposal for the Commission's recommendation to the General Assembly, until October 5, 2001.

The Commission received written comments on this document from Ronald R. Peterson, president of the Johns Hopkins Health System, on behalf of the Johns Hopkins Hospital; Paul Blackwood, Vice President for Planning of the Dimensions Healthcare System; Frank Monius, Assistant Vice President for Administration of the Association of Maryland Hospitals and Health Systems (MHA); and Patrick Redmon, Deputy Director, Research and Methodology, Health Service Cost Review Commission (HSCRC). Copies of these comments are attached to this report.

II. Summary of Public Comments on the Staff Recommendation

Johns Hopkins Hospital

Johns Hopkins Hospital supports Staff's recommendation to continue to regulate inpatient psychiatric services through the Certificate of Need process, and also concurs that the Commission should examine administrative ways to "ensure that psychiatric services are accessible and available to all patients." Specifically, Johns Hopkins supports the recommendation released for public comment, that hospitals in jurisdictions with three or more hospitals should require an exemption from CON review, through an action by the Commission, to close an inpatient psychiatric service. While this represents a re-imposition of the exemption review – changed by HB 994 in 1999 to a requirement of 45-day written notice and public hearing -- on hospitals in the four multi-hospital jurisdictions, Johns Hopkins agrees that such a change should receive serious consideration, so as to ensure continued geographic access, for "the State's most vulnerable residents," to inpatient psychiatric care in acute general hospitals.

With respect to an apparent shortage of inpatient psychiatric beds dedicated to children and adolescents, Johns Hopkins notes that the lack of coordination in the system of services, as well as insufficient capacity in some parts of that system – such as crisis and respite beds – contributes to unnecessary and inappropriate use of the dedicated inpatient capacity that does exist. However, because Johns Hopkins agrees that institutions with an adult inpatient psychiatry service should have greater flexibility to reconfigure existing beds to meet the needs of these populations. Consequently, Johns Hopkins endorses the recommendation that an expedited review for the addition of a child or adolescent service to an existing psychiatry program replace the requirement in the current State Health Plan for a separate CON approval for each additional category of psychiatric care. Such a change would simplify the administrative process, "yet would still ensure that any expansions or changes in services would not conflict with a coordinated planning framework developed by the Commission through the State Health Plan."

Acknowledging that its final comment goes beyond the scope of the CON process and the ongoing study of Certificate of Need review in Maryland, of which the inpatient psychiatric services working paper and recommendations are one component, Johns Hopkins "wholeheartedly supports" a revision of the current State Health Plan, "because the issues facing inpatient psychiatric care go far beyond the CON law." The comments describe characteristics of the current state of psychiatric services in Maryland that Johns Hopkins believes must be addressed as part of updating and reshaping the Plan:

- *Services for psychiatric patients are insufficiently diverse, and fragmented*. While various components of a system – inpatient, subacute, and outpatient psychiatric care, as well as outpatient rehabilitation – are available, they are not accessible in a systematic and coordinated way, and some needed components are missing. No equivalent for persons with mental illness exists to the inpatient rehabilitation, nursing and assisted living levels of care available to those with physical illness or injury. No statewide authority or effort is acting "to ensure the availability, accessibility, and quality of most of the services that do exist."

- *There are three categories of dually diagnosed patients whose needs are not adequately addressed, and whose condition may actually be aggravated by the disjointed and haphazard nature of existing services*: patients with both developmental disabilities and a mental illness, with both a psychiatric condition and a substance abuse or addiction problem, and with both a medical and a psychiatric condition. For the latter group especially, neither the available services nor the hospital rate-setting system are "designed for long inpatient stays."

Johns Hopkins urges the Commission, in its update of the State Health Plan, to identify the specific needs of these populations and the services and resources needed to address them, and to work with the other involved State agencies "to ensure that the reimbursement system is designed to facilitate the development and implementation of a coordinated system of care."

Dimensions Healthcare System

Paul Blackwood, Vice President of Planning for Dimensions Healthcare System of Prince George's County, also submitted comments in support of the recommendation to continue regulating inpatient psychiatric services through Certificate of Need. Dimensions specifically opposes any change in Commission statute that "would allow for the further closure of State psychiatric hospitals and beds," because its emergency departments and inpatient units "remain congested with many chronic patients more appropriately served by the State system."[1] With regard to the recommendation that the requirement of the current State

[1] The Working Paper's Option 5, which proposed the deregulation of State psychiatric hospitals operated by the Mental Hygiene Administration from CON review, in effect would only change the CON requirement to establish a new State hospital. HB 994 removed the requirement that State hospitals obtain a CON exemption to close, in favor of the same 45-day notice and public informational hearing required before the closure of hospitals in jurisdictions with three or more hospitals. Consequently, the Commission has had no authority over the proposed closure of a State psychiatric hospital since 1999.

Health Plan for separate CON approval for each additional category of inpatient psychiatry service be changed to permit either a CON exemption or Staff determination, Dimensions can support this change only if the Commission continues the current Plan's requirement that hospitals proposing to add child or adolescent services create a "separate, specialized unit with Board certified child/adolescent psychiatrists and specialty staff."

From a larger perspective than the recommendation at issue, which is part of the larger, legislatively-mandated study of the Certificate of Need program in Maryland, Dimensions endorses the comments submitted by Michael J. Kaminsky, M.D., Clinical Director of the Johns Hopkins Department of Psychiatry and Behavioral Science, which were summarized in the September 13, 2001 Staff report and recommendation. Dimensions agrees that "the current mental health system in Maryland is broken," and offers as further evidence of that fact the "tremendous difficulties" experienced by both Prince George's Hospital Center and Laurel Regional Hospital in finding placements both to avoid inpatient admission, and to step patients down after inpatient stays.

The Association of Maryland Hospitals and Health Systems (MHA)

MHA's comments, focusing on the consensus among commenters on the Working Paper that the CON program is not among the pressing and difficult problems facing providers of inpatient psychiatric services, express its concern that the Commission's recommendations "do not appear responsive to the fundamental issues facing the psychiatric system." Instead of proposing to "[work] with other state agencies on behalf of the psychiatric community to support adequate reimbursement and service levels," The recommendations seem to emphasize "further regulation," by proposing to re-impose the requirement that plans to close any psychiatric hospital service obtain a CON exemption from the Commission, regardless of the setting or the number of facilities in a jurisdiction. MHA believes that "MHCC's intervention" should come before "the provider is so desperate as to have to close the service," and not simply after that decision has been reached. MHA urges the Commission to "rethink [its] recommendations . . . to incorporate more proactive and supportive policies," with the purpose of "strengthening and shoring up the current system before it is too late."

Health Services Cost Review Commission(HSCRC)

Patrick Redmon, HSCRC's Deputy Director for Research and Methodology, notes the "inherent difficulties in establishing reimbursement policies for psychiatric cases because of their very nature," because they are more difficult than other categories of inpatient care "to clinically define." Because HSCRC "recognizes that incentives within Maryland's mental health system . . . should direct psychiatric patients to the appropriate venue" for treatment, it is committed to "continue the necessary work" to address some of the unintended consequences that the new rate-setting system has caused for inpatient psychiatric services in acute general hospitals.

HSCRC has already made progress toward a further refinement of the case mix methodology it applies to rate-setting for acute care hospitals. For example, during FY 2001, HSCRC staff began applying a more sensitive grouping mechanism to cases at the Johns

Hopkins Hospital and the University of Maryland Medical Center; using a more refined system of quantifying the appropriate cost of care within specific diagnoses and conditions should prove particularly valuable for more specialized cases, including psychiatric services. In addition, Deputy Director Redmon notes that HSCRC recently added "a special DRG to better reflect the cost of treating patients dually diagnosed as developmentally disabled with psychiatric disorders. This was undertaken "in direct response to a request by the Developmental Disabilities Administration and the Mental Hygiene Administration, who believed that a number of acute general hospitals resisted admitting dually diagnosed patients." This new method of weighting these cases is designed to "more appropriately reflect the hospital's costs in treating this special class of patients."[2]

HSCRC has also been instrumental in developing the prospective payment system to be implemented for Maryland's private psychiatric hospitals, as "a step in the effort to align efficiency and payment initiatives" in that inpatient setting. HSCRC's comments also note that the Medicare, Medicaid, and S-CHIP Adjustment Act of 1999 (PL 106-113) requires the Secretary of Health and Human Services to report to Congress by November 2001 on the development of a Medicare prospective payment service for psychiatric hospitals. Whether the result would be a Medicare-only payment system applicable to Maryland's private psychiatric hospitals, or the ability through a waiver to bring Medicare recipients into the State's own private psychiatric hospital PPS, this and other actions by HSCRC will have helped to address some of the difficulties related to reimbursement by public payers faced in recent years by the private hospitals.

III. Staff Response and Recommended Action

In carrying out the 1999 legislative mandate to examine the Certificate of Need program in Maryland, Staff has sought to keep the focus of the Working Papers, the analysis of public comments, and its recommendations to the Commission trained on the subject of CON review, and, for each health care service, the particular issues that arise from CON's focus on regulating market entry and service capacity. For each of the seventeen health care services examined, over nearly two years, Staff has presented issues and analysis related to the supply and distribution of the service throughout the State, to how the service is used and reimbursed, to how the service is regulated across all involved agencies and also in the 36 other states with CON review, and to other mechanisms through which the service might be regulated – or not regulated, at least by Certificate of Need. Because of the breadth and complexity of issues involving each of these health care services, keeping the focus on CON regulation – while providing a complete context of capacity, utilization, payment, and alternative approaches – has proved to be a demanding discipline, but a necessary one.

Consequently, the "concern" expressed by the Maryland Hospital Association, that Staff does not go beyond the scope of the CON study, or beyond even the authority of the

[2] MHCC staff was approached in April 2001 about this issue by Brian Hepburn, M.D., the Mental Hygiene Administration's Clinical Director, and Leslie McMillan, DDA Statewide Coordinator for Special Populations, formed a workgroup, and provided data analyzing the extent of this specific population presenting to acute general hospitals in Maryland.

Commission, in formulating its proposed recommendations on CON regulation of inpatient psychiatric services, seems misplaced. Because the General Assembly expects the Commission to have examined thoroughly the issues surrounding the regulation of each service through the CON process and to recommend whether to continue to do so, that is necessarily the focus of the Commission's recommendation related to inpatient psychiatric services. Because the combined effect of all the problems facing the provision of inpatient psychiatric care – the impact of rate regulation on some acute general hospitals' admission practices and on length of stay, the continuing financial crisis of private hospitals, State budgetary constraints and the mandate to downsize State hospitals, plus the nursing shortage and the constraints of managed care – is increasingly to endanger continued access to this service, Staff believes that its concern about the ability of hospitals in the most populous jurisdictions – and all State hospitals – to close quickly and without any Commission action is an appropriate concern. The Commission recognizes the limitations inherent in reviewing and acting upon a proposed hospital or service closure, but is charged with protecting access to care as an essential part of its mission.

That said, Staff completely agrees that the Commission has an important role to play, as it undertakes the updating and revision of the State Health Plan for psychiatric services, in addressing the continuum of psychiatric services. The Commission has a long history of working with other state agencies on behalf of the psychiatric community – convening the workgroup that led to HSCRC's rate adjustment to encourage hospitals to admit patients dually diagnosed with developmental disabilities and mental illness, exploring the inappropriately long stays in emergency departments of psychiatric patients waiting for beds – and looks forward to continuing and expanding that work.

However, as the Working Paper and the subsequent analysis of the public comment observe repeatedly, the challenges facing providers of inpatient psychiatric services in all three settings are not presented by the CON program, and in fact go beyond issues related to bed or facility capacity. As Dr. Kaminsky observes in his comments on the Working Paper, the initial disruptions to long-standing patterns of outpatient care caused by the 1997 creation of the Public Mental Health System have resulted in an increased incidence of inpatient episodes in the State's most vulnerable mentally ill population. Concerns over the impact of long inpatient stays on the charge-per-case performance of acute general hospitals, the retroactive cost settlement system and its chilling effect on private hospital admissions – these have led to an upswing in State hospital admission and utilization, where the legislature's direction is to make the remaining State hospitals still smaller. Comprehensively addressing the future provision of psychiatric services will require HSCRC, the Department (through MHA and Medicaid), and this Commission to take act collaboratively, and to consider creative, integrated approaches to some entrenched and difficult problems. The State Health Plan update presents an important and appropriate opportunity to begin this work.

Staff Recommendation for Commission Action

Based on research and analysis undertaken in the preparation of the Working Paper, and on public comment received on that document, Staff proposed that the Commission

consider the following three recommendations to the General Assembly, on the future of Certificate of Need regulation of inpatient psychiatric services in Maryland:

1. **The Commission recommends that Maryland continue to regulate the establishment of inpatient psychiatric facilities, services, and bed capacity through the Certificate of Need review process.**

2. **The Commission recommends that an additional provision be enacted into existing statute governing the ability of hospitals in jurisdictions with three or more hospitals to close, to impose the requirement of Commission review and action through CON exemption if a proposed closure of an individual medical service means that the number of hospitals providing that service in the jurisdiction would fall below a minimum access standard to be established in the State Health Plan.**

3. **The Commission will change the State Health Plan's current requirement for a separate Certificate of Need approval for each additional category of inpatient psychiatric service, to require an exemption from CON and to establish specific standards to met for each additional category. A statutory change may be needed, in order to clarify that, for an existing adult psychiatry service in a general hospital, the addition of child or adolescent psychiatry does not constitute a "new" medical service, requiring CON approval.**

Staff reiterates its first recommendation, that the Commission continue to regulate the establishment of psychiatric beds and facilities by means of the Certificate of Need process.

Recommendation 3 also remains the same: Staff continues to recommend a change to the present State Health Plan's requirement that an existing psychiatric facility or general hospital with an existing inpatient service obtain and additional, separate Certificate of Need approval for each category of psychiatric care. Staff will develop specific Plan standards to guide the review and approval of the proposed additional service, which will be included in the update and revision of the Plan, and thereby receive extensive additional public comment as part of the regulatory review process. These would include consideration of requirements for Board-certified specialists in the service to be added, specialized staffing, and separate clinical space and programs. Consequently, Staff will develop the appropriate regulatory standards in its update of the State Health Plan, and solicit comment on them during the regulatory review process.

As for Recommendation 2, while it continues to support the intent of the changes and clarifications it proposes to the Commission's statutory and regulatory authority with regard to inpatient psychiatric services, Staff proposes to address this issue first in the context of the update of the State Health Plan. Rather than seeking to clarify the provisions of HB 994 governing the ability of hospitals in certain jurisdictions, and all State hospitals, to close psychiatric services without Commission action, Recommendation 2 will now propose that Staff work in consultation with the Mental Hygiene Administration, HSCRC, and any other State agency or existing provider with expertise and insight on the subject, to define in

regulation the criteria for minimum access to inpatient psychiatric services. Having established this baseline for geographic access to these services as part of the State Health Plan, the Commission can then determine whether it wishes to incorporate this standard into the statute governing hospital and medical service closures, and to thereby re-impose a requirement to obtain an exemption from CON to close any inpatient psychiatric service, once previous closures reduce available psychiatric services below that minimum access threshold. Therefore, Recommendation 2 will now read as follows:

2. The Commission recommends that standards for minimum geographic and financial access to inpatient psychiatric services be adopted in the revised State Health Plan for Psychiatric Services, and that consideration be given to referencing these standards in any future clarification of statute governing the closure of hospitals or essential medical services.